A.I.D. EVALUATION HIGHLIGHTS NO. 16

FAMILY PLANNING IN HONDURAS:
AN EVALUATION OF USAID ASSISTANCE

June 1993

PN-ABG-012

SUMMARY

The Agency for International Development's (A.I.D.) family planning assistance is having an important long-term impact on both health and demographic conditions in Honduras. Despite strong cultural, political, and socioeconomic obstacles, A.I.D. has made an important contribution to family planning in Honduras during its 27-year involvement in the population sector. In 1976, the national contraceptive prevalence rate was 12 percent. Today, this rate has risen to nearly 47 percent.

Honduras is an important case because it reflects the kinds of problems that population projects encounter in many Latin American countries. Honduras, like much of Latin America, is often characterized as having a male-dominated culture ("machismo") that favors large families and does not empower women. Politically, there is resistance to U.S. interference in local affairs, and family planning has been one of the most sensitive and resented aspects of U.S. foreign assistance. Catholic Church doctrine, to which most Hondurans subscribe at least nominally, strongly opposes family planning. Widespread poverty, low educational levels, and a dispersed rural population are other constraints. Clearly, such obstacles make family planning programs slower in producing results and more expensive than they otherwise would be. However, the Honduras case shows that A.I.D. can still get results under such conditions.

A.I.D. supports two separate family planning providers in Honduras. The principal recipient of A.I.D. assistance is the Honduran Family Planning Association (ASHONPLAFA), a private nonprofit organization affiliated with the International Planned Parenthood Federation. ASHONPLAFA offers services through a national network of family planning clinics, community-based distributors, and pharmacies. The other major A.I.D.-supported provider is the Ministry of Health, which offers family planning services through its national system of hospitals and health posts.

The Center for Development Information and Evaluation's (CDIE) case study found that the number of Honduran families using "modern methods" of family planning is growing steadily. The CDIE evaluation team estimated that between 60 and 70 percent of the total increase in the number of users and in the contraceptive prevalence rate since the 1970s is attributable to A.I.D. assistance. However, the growth of contraceptive prevalence—the percentage of women of reproductive age using contraceptive methods—has slowed in recent

years, partly because of the rapid increase in the population of women of reproductive age.

Use of oral contraceptives has declined while voluntary sterilization has increased. A surprising trend is that use of "traditional" methods (rhythm and withdrawal) is growing faster than use of modern methods. It appeared to the CDIE evaluation team, based on focus group interviews with users, that the very cautious information, education, and communication efforts of the A.I.D.-supported family planning providers may be losing ground in the public opinion arena to negative information about family planning that circulates in interpersonal networks and in the national news media.

BACKGROUND

Family planning has always been controversial in Honduras, and both the Government and public opinion have historically been suspicious and wary of it. One factor is religion. Catholic Church leaders periodically make high-visibility attacks on family planning programs. Honduras's energetic news media prominently feature these attacks, and the political and social damage to anyone caught in the line of fire can be serious. Another limiting factor has been the political left, which has often been critical of what it sees as U.S. interference in Honduran affairs. Family planning, since it is so closely associated with the U.S. foreign assistance program, has been a particularly attractive target for political extremists. A third limiting factor is poverty and underdevelopment. Low incomes, low educational attainment, poor health conditions and services, and a widely dispersed and mainly rural population make delivery of <%6>effective family planning services very difficult.<%0>

However, official public policy in Honduras has never been explicitly opposed to family planning and the Ministry of Health has offered limited family planning services for the last 25 years. These programs have been very small and not actively promoted. The Government does not have a formal policy on population or family planning. Ministry of Health executives and medical staff often pay lip service to family planning services, and then give them low operational priority or ignore them completely. Because of the Government's detachment toward family planning, the lead player in providing services has been ASHONPLAFA. The Govern<%6>ment has permitted ASHONPLAFA to work<%0> freely, without political opposition or legal difficulties.

A.I.D.'S APPROACH

A.I.D.'s support for family planning in Honduras began in 1965. Initially, all A.I.D. support was provided to the Ministry of Health. Early attempts by aggressive A.I.D. advisers to install highly visible separate family planning services in the Ministry of Health ran into political resistance and created a backlash. A.I.D. and the Ministry subsequently decided to lower the profile of the program by integrating family planning services into the Ministry's program of

health care services for women. However, once the family planning services were integrated, they virtually disappeared. Competing priorities, lack of interest and knowledge on the part of medical staff, and opposition to family planning on the part of some mid-level Ministry officials contributed to the poor performance of A.I.D.-supported family planning services in the public sector during the 1980s.

In 1990, the problem of high maternal mortality became a popular political concern in Honduras, and use of family planning methods to reduce high-risk births acquired new currency in the Ministry of Health. As a result, A.I.D. and the Ministry have recently agreed to identify "reproductive risk" as the exclusive rationale for A.I.D.-supported public sector family planning services. Demographic objectives such as reducing family size or population growth are no longer identified as program objectives. There appears to be somewhat more enthusiasm in the Ministry of Health for this focus than there was for any previous family planning program. The reproductive risk focus fits comfortably with the cultural, religious, and political norms of the country. Also, the Honduran medical and political establishments view it as a Honduran initiative, not as a U.S. imposition. However, in spite of this step forward in the policy arena, progress of the Government's family planning program continues to be agonizingly slow.

Meanwhile, A.I.D. has had much more success with family planning in the private sector through ASHONPLAFA. Since its founding in 1961, ASHONPLAFA has been the major providor of family planning services in Honduras. Until 1985, it was a small organization, which received most of its operating funds from the International Planned Parenthood Federation. Direct A.I.D. support began in August 1980, and now totals nearly $30 million, including a $16 million project that is presently under way.

Today, ASHONPLAFA is a large, national organization with employees and facilities in more than 2,200 locations throughout Honduras. It has three major service delivery systems —medical/clinical services, community services, and social marketing.

Medical/Clinical Services. ASHONPLAFA operates six regional clinics, which offer medical/clinical services. These are fully equipped outpatient clinics providing reproductive health services such as counseling, temporary contraceptive methods, voluntary surgical contraception, cancer screening, and training. ASHONPLAFA also subsidizes sterilizations performed by private physicians in cities where no ASHONPLAFA clinics exist and in some Ministry of Health facilities.

Community Services. ASHONPLAFA's community-based distribution network has 1,728 distributors throughout the country. ASHONPLAFA recruits local women who receive training courses, advertising materials, and contraceptives. The local distributors promote family planning in their communities, sell contraceptives, provide advice and assistance to users, and refer users needing other services to other ASHONPLAFA or Ministry facilities. Every 3 months, an ASHONPLAFA promoter visits each local distributor, collects ASHONPLAFA's share of the money from sales, and resupplies the distributor. The program currently has 54,200 users. This figure is about 5 <%4>percent of all women of reproductive age and represents an average of

31 users per distributor.<%0>

Social Marketing. Commercial marketing of contraceptives through private pharmacies is done by a large Honduran pharmaceutical distributor under a contract with ASHONPLAFA. Sales, concentrated in the metropolitan areas of Tegucigalpa and San Pedro Sula, have reached 385 of the country's 421 pharmacies and 178 of the 272 other stores that sell medicine in 17 cities around the country. Most of the sales offer ASHONPLAFA's "Perla" pill and "Guardian" condom.

Because of the political sensitivities about U.S. pressure and interference, A.I.D. normally lets ASHONPLAFA take the lead in policy dialogue activities. Every new Minister of Health is briefed by ASHONPLAFA on demographic trends and family planning activities taking place in the country. ASHONPLAFA ran an important A.I.D.-funded Leadership Training program for about 3 years that presented demographic statistics and information about reproductive health issues to hundreds of public and private sector leaders. A.I.D. is presently sending groups of national leaders to observe <%4>the successful Mexican family planning program.<%0>

An unplanned factor that appears to have improved the policy climate for family planning is AIDS. Honduras was one of the first countries in Central America to have AIDS cases, and it has developed a comparatively aggressive program to combat the epidemic. The Government has initiated publicity campaigns openly promoting condom use, and so far the Catholic hierarchy has chosen not to take issue with this emphasis.

FINDINGS

CDIE found that the program's long-term *impact* has been measurable and significant. In demographic terms, Honduras's total fertility rate has declined from more than 7 children per family in the 1960s and 1970s to about 6 in 1981 and to almost 5 in 1992 (see Figure 1). Some of the fertility decline is due to the growing availability of A.I.D.-supported family planning services, along with other factors such as improvements in education and economic growth. The most straightforward indicator of coverage is the number of users of family planning nationwide. Figure 2 shows that the number of users has increased steadily during the period covered by the surveys, more than doubling during the 1980s. Since almost all of the contraceptives and services in Honduras are A.I.D.-supported, this increase is a direct indication of A.I.D. program effects.

However, the total number of users only tells part of the coverage story. Since the population of women of reproductive age is increasing rapidly in Honduras, contraceptive prevalence is a more important indicator than number of users. In 1976, the contraceptive prevalence rate was 12 percent. As shown in Figure 3, the overall contraceptive prevalence rate in Honduras (both modern and traditional methods) rose to 27 percent in 1981 and then to 47 percent in 1991. The prevalence rate for all modern methods increased from 24 percent in 1981 to 35 percent in 1991. However, there was little rise in modern method prevalence between 1987 and 1991.

The most surprising finding of the surveys is that the use of traditional contraceptive methods (primarily withdrawal and rhythm) increased more rapidly between 1981 and 1991 than did the use of modern methods. The prevalence of traditional methods rose from 3 percent (12 percent of all contraceptive users) in 1981 to 12 percent (26 percent of all users) in 1991.

Given the contraceptive prevalence rate of 47 percent, fertility in Honduras should be somewhat lower than it is. The extensive use of ineffective traditional methods, high discontinuation rates, relatively low use-effectiveness of contraceptives, and the early onset of childbearing are some of the factors that may explain the higher-than-expected fertility rate.

Family planning has also had an important impact on health conditions. The most important fertility-related factors affecting infant and maternal mortality appear to be the age of the mother at first birth, the interval between births and the number of children a mother has. During the mid-1980s, the infant mortality rate (IMR) was 77.4 deaths per 1,000 live births for young women under the age of 20, compared with an IMR of 48 for births to women aged 20 to 34. Similarly, the infant mortality rate for children born after a long birth interval (24 months or more) was 42 deaths per 1,000 live births, compared with 68 deaths per 1,000 births for children born following a short (under 24 months) birth interval. In other words, the mortality risk is 61 percent higher for closely spaced births, compared with birth intervals of 2 years or more. Fear of HIV/AIDS has caused condom use to increase slightly, from 1 percent (1984) to 3 percent (1991), a level too low to have measurable impact on the spread of HIV/AIDS among the population.

In terms of program *effectiveness*, CDIE found that the coverage and quality of care offered by A.I.D.-supported family planning providers varies greatly. In ASHONPLAFA clinics, the quality of services is generally good, but there is a problem of inadequate coverage of the clinical services for women in remote areas. Conversely, Ministry of Health services offer good geographic coverage, but the quality of attention they give to clients is often poor. Almost all Ministry facilities have A.I.D.-supplied contraceptives available, but medical staff is overworked and facilities are overcrowded. Curative services often take priority over family planning consultations.

ASHONPLAFA clinics give better information and instructions to clients than does the Ministry, but information given to clients appears insufficient almost everywhere. For example, clients of both the Ministry and ASHONPLAFA reported in CDIE focus groups that they received information only on the specific method they were using and that they had not been given information on other methods. Because of limited information provided to the public and to clients, rumors and misinformation about the dangers and side-effects of contraceptives are rampant.

Misconceptions about family planning prevail in both urban and rural areas, making women afraid of using family planning. Moreover, medical staff is not always friendly and attentive at Ministry facilities. Women reported long waits, being turned away because of too many patients, and lack of privacy at Ministry clinics. The physical infrastructure and equipment

of Ministry facilities were minimal, overutilized, and understaffed. ASHONPLAFA staff, on the other hand, were said to be reassuring and supportive. Waiting time averaged only 45 to 60 minutes and facilities were clean, well kept, <%6>well equipped, and provided safe sterile procedures. <%0>

Sustainability—the ability of providers to continue to provide good services after A.I.D. support ends—is a major concern of the Honduras program. ASHONPLAFA, faces problems with financial sustainability, whereas the Ministry of Health faces both institutional and financial problems with regard to sustainability.

CDIE found that ASHONPLAFA has a good institutional base for sustaining its services on its own in the future. The organization has expanded its facilities and staff without compromising service. Its infrastructure is well-situated, well-designed, and well-maintained. ASHONPLAFA does not depend on outside advisers and its leadership is experienced, professional, and committed. It has earned the respect and confidence of the Honduran medical and political establishments, giving it legitimacy and stature.

In terms of financial sustainability, however, ASHONPLAFA is in a more precarious position. It is very dependent on A.I.D. funding. At A.I.D.'s urging, it has raised prices and increased its revenues. However, ASHONPLAFA still feels caught between the need to generate income and the need to expand services to poor families. ASHONPLAFA wishes it had another independent source of income such as a business or an endowment.

The Ministry of Health, on the other hand, has a weak institutional base for sustaining family planning services on its own. One problem is staff. Senior management consists of political appointees, and medical staffing depends heavily on medical students who are on obligatory temporary field assignments. Administrative structures are cumbersome, bureaucratic, and underfunded. While A.I.D.'s major Health Sector projects are trying to address some of these weaknesses, improvement in family planning services has been extremely slow.

Financial sustainability, on the other hand, should be less of a problem for the Ministry of Health than for ASHONPLAFA. The Ministry has a permanent, fairly predictable budget from the Honduran Government. Ideally, Government budgetary resources for health services will increase in the future, with a growing proportion of the health budget going for preventive and primary care, including reproductive health and family planning. The CDIE evaluation team believes, however, that budget austerity, competing demands for funds, and lingering political wariness about family planning make it unlikely that government family planning services will receive adequate funding for good quality, national-scale coverage in the foreseeable future.

Overall, the CDIE team concluded that A.I.D. will probably have to accept the reality that sustainability is a very long-term objective. Honduras will need continuing A.I.D. support for a number of years for family planning objectives, including eventual sustainability, to be met.

In terms of *efficiency,* CDIE found that ASHONPLAFA costs increased during the 1980

to 1991 period and that expenditures for facilities and equipment grew faster than expenditures for personnel and administrative activities. Fortunately, the number of couple- years-of-protection (CYPs) that ASHONPLAFA produces grew even faster. As a result, the efficiency of the organization, as measured by cost per CYP, has been improving. The rapid expansion of physical facilities has created underutilized capacity, setting the stage for further efficiency improvements in the future. With improved information, education, and communication, ASHONPLAFA can generate new demand for its existing services and facilities, increasing its volume of business without having to further expand its physical capacity.

Comparing services, CDIE found that medical and clinical services are the most cost-effective ASHONPLAFA service in terms of cost per CYP. The cost per CYP of community-based distribution is twice as high, and social marketing is three times as high. Comparing methods, voluntary sterilization is the most cost-effective method, followed by IUDs. Oral contraceptives are considerably more costly per CYP.

Overall, CDIE found a generalized feeling among A.I.D.-supported family planning providers that the fear of public attacks from opponents of family planning has made the program overly cautious. There was a resolve among family planners that a somewhat more aggressive approach to promotion is needed and should be tried. Exactly how aggressive is a tactical question that needs to be answered in the field. The institutional conditions for a larger and eventually sustainable program have been created by A.I.D. If the public information battle can be won, the program appears to be poised for greater success during the remainder of the 1990s.

LESSONS LEARNED

1. A.I.D.-supported family planning programs can achieve acceptable results even in the face of strong cultural and political obstacles found in Latin America. A persistent but low- key approach has been relatively successful in balancing conflicting political interests.

2. Programming A.I.D. family planning assistance simultaneously in both the public and private sector is a sound strategy as long as the activities in the two sectors complement each other. In the Honduran case, both ASHONPLAFA and the Ministry of Health have performed valuable services in Honduran family planning.

3. In a potentially hostile environment, A.I.D. can most effectively promote family planning exclusively as a health intervention to reduce high-risk births. This focus fits comfortably with Latin American social and religious norms.

4. Weak information, education, and communication activities have negative consequences for both the coverage of family planning services and quality of care. The Honduran case points to the need for more effective client information services to expand coverage and to counteract harmful misinformation.

5. Charging fees does not appear to be an obstacle to widespread use of family planning. In the long run, however, private family planning providers (like ASHONPLAFA) would benefit from an independent source of revenue, such as an income-generating business or an endowment, to help achieve financial sustainability while keeping fees within reach of low-income families.

6. Progress in family planning in a country like Honduras is slow and uneven, requiring patience and a long-term commitment on the part of A.I.D. In the Honduran environment, insistence on quick results could be counterproductive.

OUTSTANDING ISSUES

Several important and unresolved questions arose in the course of this case study.

- *What are the causes and consequences of the growth of "traditional" family planning methods?* The surprising finding that ineffective traditional methods are spreading more rapidly than the more effective "modern methods" supported by the A.I.D. program could not be fully explained. In the long term, it is not clear whether traditional methods will be beneficial or detrimental to the family planning services A.I.D. promotes.
- *Can A.I.D.'s population programming be linked to programming in other A.I.D. sectors?* The powerful relationship between education, family planning, and health is clearly important, but its program implications need more study. Are there ways that A.I.D. programming in different sectors could be synchronized to capitalize more effectively on beneficial interactions among them?
- *What kind of policy dialogue works?* The agonizingly slow progress in public sector family planning acitivities in Honduras stands in stark contrast with other countries such as Mexico, where national leadership has strongly endorsed family planning, resulting in greatly improved program performance. What more could A.I.D. do that might produce a similar policy breakthrough in Honduras?

This Evaluation Highlights summarizes the findings from the report A.I.D.'s Family Planning in Honduras, Technical Report No. 9, June 1993 (PN-AAX-266), which can be ordered from the DISC, 1611 North Kent Street, Suite 200, Arlington, VA 22209-2111, telephone (703) 351-4006; fax (703) 351-4039.